October 31, 1996

Honorable James B. King
Director
U.S. Office of Personnel Management
Washington, D.C. 20415

Dear Mr. King:

I respectfully submit the Office of the Inspector General's Semiannual Report to Congress for the period April 1, 1996 to September 30, 1996. This report describes our office's activities during the past six-month reporting period. As reflected in the report, we continue to be encouraged by the positive results we have achieved.

Should you have any questions about the report or any other matter of concern, please do not hesitate to call upon me for assistance.

Sincerely,

Patrick E. McFarland
Inspector General

Table of Contents

Message From the IG

Since the beginning of my tenure as Inspector General (IG) of the Office of Personnel Management (OPM), no area has occupied more of my time than oversight of the Federal Employees Health Benefits Program (FEHBP). Each of our semiannual reports has shown significant strides made through our audits, investigations and debarment authority to find, prosecute, and deter fraud, waste and abuse in this program. I am appreciative of the cooperation that we have received from OPM's directors and program officials to improve our efforts in this area.

We have also been pleased by the increased concern shown by Congress and the Administration in dealing with health care fraud that was highlighted by the enactment of P.L. 104-191, the Health Insurance Portability and Accountability Act of 1996 (Act). In light of the high priority this agency and this office have given to health care fraud, I was shocked when the FEHBP was excluded from several antifraud initiatives extended to all other federal health care programs under this Act, apparently because inaccurate information had been provided to congressional committees by private sector entities. Specifically, we have learned that groups wishing to see the FEHBP exempted from improved antifraud measures had incorrectly characterized it as a program with little federal presence and which relied principally on community-rated plans, i.e., health maintenance organizations (HMOs), as a means of providing coverage.

I would like to use this opportunity to set the record straight regarding the manner in which the FEHBP is operated and to explain why the program and its participants deserve the strongest form of antifraud protection available under current law.

In fact, the FEHBP is the largest employer-sponsored health insurance program in the United States. It provides health coverage to approximately 9 million persons--federal employees, annuitants, and their family members--throughout the country under contracts negotiated by the Office of Personnel Management with approximately 400 health insurance carriers. Total annual premium payments under these contracts are in excess of $17.2 billion. Through a statutory formula, the costs of coverage are shared by the government and the individual program participants, with the federal payment amounting to approximately 72 percent, or over $12.3 billion for the current contract year. All FEHBP-associated funds from both agencies and participants, as well as a directly appropriated payment for annuitants, are paid into a trust fund administered by OPM, and have always been considered to be federal funds in their entirety.

As is the case with all health insurance plans, regardless of their sponsorship, the FEHBP is moving toward greater reliance on managed care. However, it is still primarily a fee-for-service program. Approximately 71 percent of persons insured under the FEHBP are in fee-for-service plans, while 29 percent are in HMOs. In fiscal year 1995, approximately 40 percent of all persons insured under the FEHBP were in a (fee-for-service) Blue Cross and Blue Shield plan.

The FEHBP has consistently been recognized as a model of the way in which a health insurance program can control costs and operate with a minimum of overhead. Far from reflecting an absence of involvement by federal officials, the program is actively managed to provide a choice of benefits in the health insurance marketplace. The federal presence facilitates, rather than hampers, this process. For example, the fee-for-service carriers which underwrite these FEHBP contracts have a much lower risk of loss than when dealing with a private sector firm, because the government maintains a separate contingency reserve for each carrier and contractually agrees to pay that reserve to a carrier should the carrier suffer an accumulated loss on the contract at contract termination.

In this context, I consider it especially ironic that the FEHBP should have been excluded from many of the most significant benefits of new legislation that have, as a principal objective, the strengthening of antifraud protections for all federal health care programs. Had my office and the responsible OPM program offices been consulted on this matter, we would have vigorously opposed the removal of the FEHBP from the Act's provisions granting, among other taxpayer benefits, the following:

- *Social Security Act criminal sanctions for fraud and abuse*, providing for the extension and expansion of current criminal sanctions for fraud and abuse in the Social Security program to all health care programs funded in whole or in part by the federal government, including the Medicare/Medicaid anti-kickback provision.

- *Mandatory exclusion of certain felons,* establishing a new mandatory exclusion from participation in federal health care programs for individuals convicted of felonies relating to health care fraud or controlled substances.

- *Expanded and enhanced civil monetary penalties,* extending increased Medicaid and Medicare civil monetary penalties to other federal health care programs for such offenses as incorrect coding; billing for medically unnecessary services; false claims; and persons offering remuneration, including waiving coinsurance and deductibles.

- *Health Care Fraud and Abuse Control Account,* providing agencies with a source of funding to assist them in investigations, prosecutions, audits or evaluations of health care fraud and abuse. This account is administered by the Attorney General and the Secretary of Health and Human Services and is funded by criminal fines, civil False Claims Act recoveries and civil monetary penalties in health care cases. The FEHBP's current exclusion from this new health law prevents OPM's full participation in this account, thereby limiting access to these funds.

The Office of Personnel Management's predecessor, the U.S. Civil Service Commission, conducted an active program of audits from the inception of the FEHBP in 1960. These audits have continued to date without interruption since the agency's reorganization and renaming in 1979. When my office was constituted as a statutory entity in 1989, we assumed responsibility for performing the audits and, for the first time, also provided criminal investigations of fraud, false claims, and other program-related offenses. In 1993, we

developed and implemented a debarment activity that removes from FEHBP participation health care providers who have acted improperly against federal programs. Because of these efforts, we have compiled a substantial record of accomplishments that directly benefit the financial interests of the FEHBP and protect the health care interests of its subscribers. For example, during the past three fiscal years, our audit and investigations programs have generated $249 million in net positive financial impact in favor of the FEHBP trust fund. During the approximately equivalent period since our inception of administrative sanctions activities, we have debarred 5,200 providers. These financial recoveries produce corresponding reductions in FEHBP premium costs for the government and program subscribers, while the debarments remove providers who constitute actual or potential threats to FEHBP's fiscal integrity or to the physical well-being of subscribers.

While our record of accomplishments has been substantial, the very large financial and human scale of FEHBP dictates that we must continue to search for stronger, more effective means to protect the program. The additional fraud-fighting weapons made available to other agencies by this Act should be equally applicable to FEHBP. As the official directly vested with responsibility for combating fraud in OPM programs, I am appalled that any person or group should have desired to limit the authority of my office and other federal law enforcement entities to investigate wrongdoing in connection with the health care of federal employees, annuitants and their families. I pledge to work with my agency, the Administration and Congress to correct the egregious error made by our exclusion.

Productivity Indicators

FINANCIAL IMPACT:

Audit Recommendations for Recovery of Funds $42,187,316

Recoveries Through Investigative Actions $1,180,628

Management Commitments to Recover Funds $32,645,550

ACCOMPLISHMENTS:

Audit Reports Issued 32

Investigative Cases Closed 28

Cases Accepted for Prosecution 22

Indictments 9

Convictions 10

Hotline Contacts and Complaint Activity 1119

Health Care Provider Debarments and Suspensions 834

Evaluation and Inspections Reports Issued 2

Statutory and Regulatory Review

As is required under section 4 (a)(2) of the Inspector General Act of 1978 (IG Act), as amended, our office monitors and reviews legislative and regulatory proposals for their impact on the Office of the Inspector General and Office of Personnel Management programs and operations. Specifically, we perform this activity to evaluate their potential for encouraging economy and efficiency and preventing fraud, waste and mismanagement. We also monitor legal issues that have a broad effect on the Inspector General community.

During this reporting period, we examined numerous legislative proposals affecting OPM programs. Some of these legislative proposals are highlighted below.

Legislative Review

Federal Employees Health Benefits Provider Integrity Amendments

As stated in our previous semiannual reports, OPM Director James B. King has twice submitted to Congress a legislative proposal developed by the agency with the assistance of the OIG that would significantly streamline procedures under 5 U.S.C. § 8902a for OPM-initiated debarments under the Federal Employees Health Benefits Program. During the 104th Congress, this proposal was introduced as section 603 of H.R. 3841, the Omnibus Civil Service Reform Act of 1996. The House initially defeated this bill on September 26, 1996, on issues unrelated to the debarment proposal. After revising the bill, but not the section dealing with debarment of health care providers found to have engaged in fraudulent practices, the House approved H.R. 3841 by a voice vote on September 27, 1996. No action was taken by the Senate prior to adjournment of the 104th Congress.

This legislation would provide us with an efficient mechanism apart from common rule debarments to remove fraudulent health care providers from the FEHBP. We will continue to work vigorously with the agency to achieve consideration of this legislative package.

Health Care Debarment Reform Passes House

Health Insurance Portability and Accountability Act of 1996

As discussed fully in the Message from the Inspector General, during the 104th session of Congress, President Clinton signed P.L. 104-191, the Health Insurance Portability and Accountability Act of 1996. Title II of this Act contains provisions that extend health care antifraud measures to all federal health care programs previously available only under Medicare and Medicaid.

However, apparently because of a misunderstanding of the nature of the Federal Employees Health Benefits Program, the FEHBP was singled out and removed from the definition of "federal health care program" in this legislation. This action has resulted in the exclusion of OPM from the ability to utilize the enhanced antifraud tools provided to other federal agencies in our efforts to eliminate fraud, waste and abuse in the FEHBP. Specifically, we are excluded from enhanced anti-kickback provisions, new mandatory exclusion of certain felons, as well as expanded and enhanced civil monetary penalties.

We only became aware of removal of the FEHBP shortly before final enactment of the legislation and since then have been diligently working to have a technical amendment introduced to correct this serious error. My office has been coordinating with the Department of Justice and the Department of Health and Human Services to facilitate consideration of this proposal along with their respective changes. Unfortunately, our efforts were not successful before Congress adjourned. We have informed some concerned members of Congress of this issue and intend to place the highest priority on effectuating consideration of the technical amendment in the next Congress.

Serious Deficiency Present in New Health Care Legislation

Audit Activities

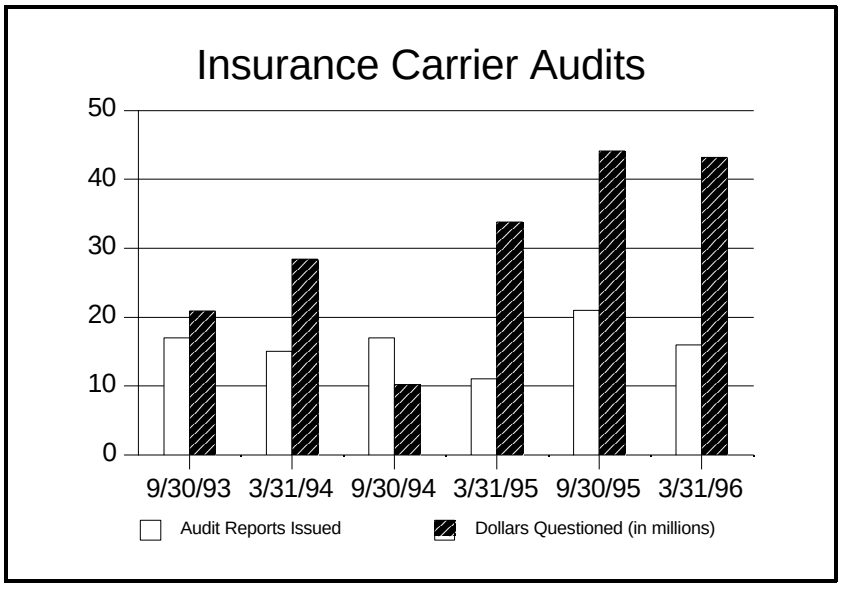
Health and Life Insurance Carrier Audits

The Office of Personnel Management contracts with private sector firms to underwrite and provide health and life insurance benefits to federal employees, annuitants, and their dependents and survivors through the Federal Employees Health Benefits Program and the Federal Employees' Group Life Insurance Program.

Approximately 515 different health insurance carriers, sponsors, and underwriting organizations, as well as two life insurance carriers, are involved in these programs, sharing in annual premium payments in excess of $17.2 billion. Our Office of Inspector General is responsible for auditing their operations.

During the current reporting period, we issued 28 final reports on organizations participating in the FEHBP, 22 of which contain recommendations for monetary adjustment in the aggregate amount of $42.2 million due the FEHBP and four which did not contain any monetary recommendations. Two of these reports covered special requests initiated by the contracting officer. A complete listing of these reports is provided in Appendices III-A and III-B on pages 37-39 of this report.

We feel it is important to illustrate the dollar significance resulting from our audits of FEHBP carriers and what this means to the FEHBP trust fund. For instance, during the past six semiannual reporting periods, the OIG issued 97 reports and questioned $180.6 million in inappropriate FEHBP charges as the graph below illustrates.



The sections that immediately follow explain the differences among the types of FEHBP carriers and include several audit report summaries of final reports issued during the past six months.

Community-Rated Plans

Approximately 400 of the FEHBP contracts represent community-rated, comprehensive medical plans, also known as health maintenance organizations. A community-rated carrier generally sets the subscription rates for benefits on the basis of an average revenue requirement for each member. Under current statutes for HMOs, subscription rates can vary from group to group as the result of adjustments for factors such as the age and sex distribution of a group's enrollees (community rating by class) or its projected utilization of benefits (adjusted community rating). However, once a rate is set, it may not be adjusted to actual costs incurred or actual utilization. The inability to adjust to actual costs or utilization distinguishes community-rated plans from experience-rated HMOs, indemnity, or service benefit plans.

Prior to 1991, all community-rated carriers were required to submit a certificate of community rating, certifying that the rates offered to OPM were in fact the community rates being offered to all groups, adjusted for benefit differences. OIG's audits of community- rated plans were designed to verify that the community rates certified to OPM were being consistently charged to **all** groups. If an audit disclosed that the carrier had offered some groups rates lower than the community rates, then a condition of defective community rating (DCR) exists. OPM regulations and FEHBP contract clauses provide that OPM is entitled to a downward rate adjustment. This adjustment reflects the fact that, as a result of accepting community-rating principles, OPM has given up the right to negotiate rates on a competitive basis.

In 1991, OPM revised its regulations to require that subscription rates charged to the FEHBP be equivalent to the rates charged those subscriber groups closest in size to the FEHBP and whose respective contracts contain similar benefits. These similarly sized subscriber groups are called SSSGs. Under these regulations, each carrier must certify that the FEHBP is being offered equivalent SSSG rates by submitting to OPM a certificate of accurate pricing. These rates are determined by the FEHBP-participating carrier, which has the responsibility of selecting the two groups that qualify as SSSGs. During an audit, should our auditors determine that equivalent rates were not applied to the FEHBP or that the appropriate SSSGs were not selected, then a condition of defective pricing (DP) exists. The FEHBP is entitled to a downward rate adjustment to compensate for any overcharges resulting from DP.

During this reporting period, we issued 14 audit reports on community-rated plans. The following summaries of two HMO audit reports issued during the period illustrate a number of problems encountered in applying and enforcing community-rating principles within the FEHBP.

Columbia Medical Plan
in Columbia, Maryland

Report No. 67-00-92-079

June 28, 1996

Columbia Medical Plan (Columbia), a wholly owned subsidiary of Blue Cross and Blue Shield of Maryland, has been an FEHBP participant since 1971. In 1987, Columbia Medical Plan was publicly marketed along with Free State Health Plan (Free State) under the name Columbia Free State Health System. Columbia is a community-rated comprehensive medical plan that provides services to its members throughout the Baltimore-Washington metropolitan area. During the contract periods covered by our audit (1987-1991), FEHBP premiums paid to Columbia totaled nearly $82,517,000. In 1991, the FEHBP's premium payments were approximately $20,726,000, representing about 24 percent of Columbia's premium revenue that year. Enrollment statistics for 1991 indicate that 13,137 FEHBP members were enrolled in the plan that year.

Our audit resulted in questioned costs of $9,440,478, representing improper charges relating to premium rates, a Medicare loading resulting in an upward adjustment to the cost of the basic benefits package, and drug copayment benefits. Our auditors calculated an additional $2,551,671 for lost investment income. These and other findings are discussed below.

Premium rates: After examining the premium rates charged to the FEHBP by Columbia for contract years 1987-1991, our auditors determined that the plan was not in compliance with its FEHBP contract in regard to its rate-setting practices from 1987-1990. This resulted in a violation of the plan's certificates of community rating and premium overcharges to the FEHBP of $9,423,282 during those four years. It should be noted that during an earlier audit of this plan in 1986, the plan was also cited for questionable rating practices. In contract year 1991, however, the rates that Columbia charged the FEHBP were in compliance with the pricing provisions of its FEHBP contract.

In 1987, Columbia did not charge the FEHBP the same standard rate given to several of the plan's other groups, resulting in excessive premiums paid by the FEHBP of $941,421. In 1988 through 1990, we found that the plan offered discounts to selected groups not offered to the FEHBP that resulted in findings of defective community rating for each of those years as well. We determined that the plan's community rating violations for each of those years entitled the FEHBP to premium adjustments totaling an additional $8,481,861.

Auditors Cite Health Insurance Carrier for Defective Community Ratings

Medicare loading and drug copayment benefits: We also questioned the plan's 1987 Medicare loading to the FEHBP, because the plan was unable to provide documentation to support its charges ($17,196). In 1990, the plan overcharged the FEHBP $215,531 for a drug copayment benefit that was calculated at $2 rather than the $5 copayment actually purchased by the FEHBP.

Lost investment income: Consistent with FEHBP regulations, we were able to determine that the amount due in lost investment income to the FEHBP from 1988 through 1995 calculated on DCR overcharges for contract years 1988 and 1989 was $2,551,671. The FEHBP also is due additional amounts for the period January 1, 1996, until the funds have actually been returned to OPM.

Enrollment system: We reviewed the plan's enrollment system to verify the accuracy of its federal enrollment statistics reported to OPM. Our review showed that Columbia had variances of 6.1 percent for 1990 and 1991. Based on these differences, we recommended that the OPM contracting officer remind the plan of its enrollment reconciliation obligation to the FEHBP and offer the plan assistance in this area if needed.

Inadequate internal controls: Our review showed that Columbia did not have adequate controls to assure compliance with the regulations governing FEHBP community-rated carriers. The resulting deficiencies had an obvious detrimental impact upon the FEHBP as described in the foregoing paragraphs. Our findings of $11,992,149 in questioned costs to the FEHBP contrast sharply with the amount ($964,093) the plan agrees with.

Auditors Recommend $11,992,149 Be Returned to FEHBP Trust Fund

Qual-Med Health Plan - New Mexico in Albuquerque, New Mexico

Report No. PX-00-93-26

August 28, 1996

Qual-Med Health Plan - New Mexico (Qual-Med), formerly Foundation Health Plan (FHP), entered the FEHBP on January 1, 1986, as a community-rated comprehensive medical plan. Qual-Med bought FHP in May 1989 and took over FHP's contract with OPM, operating as an individual practice HMO throughout ten counties of New Mexico. During the contract periods covered by our audit (1988-1992), the FEHBP paid Qual-Med subscription income totaling $19,631,146. In 1992, the FEHBP was the plan's largest group, comprising 17.5 percent of its membership.

This was our first audit of Qual-Med, and it resulted in questioned costs of $2,646,668. This amount represents $2,034,949 in inappropriate charges related to

defective community rating, defective pricing and a children's loading, as well as an additional $611,719 for lost investment income experienced by the FEHBP. Qual-Med agreed with only $56,601 of the questioned costs. When we compared the plan's federal enrollment statistics to those reported by OPM, we noted a discrepancy ranging from 1.9 percent to 4.1 percent during the audited period. Some of our major findings associated with this audit are described below.

Premium rates: Our auditors examined the premium rates charged to the FEHBP by Qual-Med for contract years 1988-1992 and determined that the plan had overcharged the FEHBP in each of these years. The aggregate amount of these overcharges was $1,974,512. Specifically, our review indicated that the plan was in violation of its certificates of community rating in 1988, 1989, and 1990, and its certificates of accurate pricing in 1991 and 1992 by providing selected groups with discounted rates. This resulted in a finding of defective community rating for the first three years and defective pricing for the last two. We also determined that Qual-Med used three different rating methods to determine the FEHBP's rates during this time frame but did not apply them in a consistent manner between groups in order to assure that all groups were treated impartially in accordance with OPM's regulations and instructions. In large part, the plan disagreed with our defective rate findings as well as the appropriate remedy for the overcharges to the FEHBP in each of those years. We also pointed out the plan's failure, for the most part, to maintain adequate documentation for us to review to support its rate submissions to OPM.

Children's loading: Our review disclosed that Qual-Med claimed an inappropriate children's loading for 1988, 1989, and 1992. There was no evidence to show that the plan routinely adjusted the rates for groups that required additional years of dependent coverage other than the FEHBP. Also of interest is the fact that the plan did not claim a children's loading for contract years 1990 and 1991. In accordance with OPM's rate instructions, we determined that Qual-Med's loading for overage dependent coverage for each of the years in question was not allowable. We calculated that the FEHBP was inappropriately charged $60,437 for those years and have recommended to the contracting officer that the plan be required to return that amount.

Investment income: The FEHBP is entitled to a recovery of lost investment income on findings of DCR and DP for all contract years reviewed except 1990 in accordance with FEHBP regulations. In this regard, our calculations through 1995 showed that the FEHBP is due $611,719. We have made a recommendation to the contracting officer that this amount be assessed to Qual-Med as well as additional amounts due for the period beginning January 1, 1996, until the funds have been returned to the FEHBP.

$2,646,668 Cited by Auditors for Return to FEHBP Trust Fund

New OIG Audit Initiative

We recently implemented a new audit approach for the FEHBP's community-rated carriers (HMOs) that has been designed to be quick and responsive to the needs of OPM's contracting office and which we believe may also benefit the carriers. We call this new and innovative auditing approach a "rate reconciliation" audit (RRA). This new audit supplements, not replaces, our standard community-rated audit.

Our standard community-rated audits are done on a post-award basis, usually several years after the completion of the contract years in question. RRAs differ in that they are performed **prior** to final rate settlement, thereby providing OPM program managers with detailed verification of the data supplied by the carriers to support final rate adjustments. The two HMO audit summaries that immediately precede this article describe findings using the traditional audit process we have always followed.

Rate reconciliation has always been an annual process for community-rated HMOs participating in the FEHBP. It allows these plans to adjust their proposed community rates to the rates that are actually in effect on January 1 of the contract year. Plans are required to submit rates **seven** months in advance (May of the preceding year) of the January 1 effective date of the new contract year. For instance, rates for the 1996 contract year were actually submitted in May 1995. And, in almost all instances, these are estimated rather than actual community rates. During the course of the new contract year (for our purposes, we will use the current contract year 1996), to determine if money is due either the FEHBP trust fund or the plan, each plan must recalculate its rates, basing the calculations on the plan's actual community rates effective for all groups renewing January 1, 1996. Once a determination is made regarding whether the plan or the FEHBP is due money, the options are to put the money in a special FEHBP fund reserved for the plan (a contingency fund) in the form of a debit or credit, whichever applies, or negotiate higher or lower premium rates for the next contract year.

The development and implementation of this new rate reconciliation audit process were carefully orchestrated by an RRA development team, which included the OIG and representatives from OPM's Retirement and Insurance Service (RIS), specifically the contracting office and the Office of Actuaries. The RRA concept was designed to assist OPM contracting officials in negotiating the best premium rates possible by ensuring that they have been provided with current, complete and accurate information by participating community-rated HMOs. To accomplish this, RRAs are limited to only the current year's rate reconciliation and must be performed and completed from mid-May through very early August. This time frame coincides with the period OPM's Office of Actuaries actually receives the rate reconciliation and finalizes the entire rating process.

The goal of the RRA process is to start and complete the audits, including the issuance of a report to OPM contracting officials, in about a three-week period. During the process, our audit staff is in continuous communication with representatives of OPM's Office of

Actuaries. By working as a team, premium rates can be negotiated and finalized in an efficient and timely manner.
We believe that rate reconciliation audits provide significant benefits to OPM and participating community-rated carriers in the following ways:

- Auditors are reviewing contemporary data; therefore, records and carrier staff familiar with the records should be readily available to assist in both the audit and resolution of any audit issues.

- Representatives from OPM's Office of Actuaries, as well as the insurance plans, receive almost immediate feedback relating to the audit results.

- The audit resolution process begins immediately, thus benefiting both the insurance plans and OPM through timely resolution of audit issues.

- RRAs will result in more timely and more frequent audit coverage of the universe of HMOs that participate as community-rated carriers.

- The RRAs reduce the uncertainty of future carrier liabilities that would otherwise result from a post-award audit and will avoid interest accruals.

We began doing RRAs in May 1996. By the first of August, we had completed ten audits. From OPM's perspective, the RRAs appear to have accomplished our original goals and objectives. Of the ten audits, we recommended changes to the reconciliations on seven audits, resulting in savings to the FEHBP of $6.5 million and savings to one carrier of $55,000. All seven audits were resolved by RIS in accordance with our audit recommendations. We recommended no changes on two audits. And for the remaining audit, we did not express an opinion due to complexities in reviewing their rating system and time constraints in completing the audit before the deadline for finalizing all FEHBP rates. In this particular case, the audit will be finalized at a later date in conjunction with a regularly scheduled HMO audit.

Based on the positive feedback we received from OPM's contracting office and our audit staff, we plan to expand our rate reconciliation audit effort in future years. Our current plan is to perform about 18 RRAs during the next rate-setting cycle.

New RRAs Yield Savings of $6.5 Million

Experience-Rated Plans

In addition to community-rated plans, the FEHBP offers a variety of experience-rated plans, including the Government-wide Service Benefit Plan, plans sponsored by employee organizations, and comprehensive medical plans (experience-rated HMOs). An experience rate is a rate that reflects a given group's projected paid claims, administrative expenses and retentions. Each carrier maintains separate accounts for its federal contract, and future premiums are adjusted to reflect the federal enrollees' actual past use of benefits.

Audits of these plans generally focus on the allowability of contract charges and the

recovery of appropriate credits, the effectiveness of carriers' claims adjudication systems, and the adequacy of internal controls to ensure proper contract charges and benefit payments.

Government-Wide Service Benefit Plan

This plan is administered by the Blue Cross and Blue Shield (BCBS) Association on behalf of its member plans. The association delegates authority to participating local Blue Cross and Blue Shield plans throughout the United States to underwrite and process the health benefits claims of its federal subscribers in the Service Benefit Plan. For administrative purposes, the association has established a Federal Employees' Program (FEP) Director's Office in Washington, D.C., that provides centralized management for the Service Benefit Plan, including a central claims control center known as the FEP Operations Center. This center, among other things, verifies subscribers eligibility, approves or disapproves the reimbursement of local plan payments of FEHBP claims (using computerized system edits), and maintains both a history file of all FEHBP claims and an accounting of all program funds.

The BCBS federal employee program currently consists of approximately 65 audit sites throughout the United States. As a further illustration of the importance of our BCBS audits, in 1996, approximately 40 percent of all FEHBP subscribers are enrolled in Blue Cross and Blue Shield plans nationwide.

During this reporting period, we issued two BCBS reports. The following audit summaries describe the major findings from those reports, along with the questioned costs associated with those findings.

Blue Cross and Blue Shield of Colorado in Denver, Colorado

Report No. 10-30-94-042

July 11, 1996

Blue Cross and Blue Shield of Colorado (BCBS of Colorado) is headquartered in Denver, Colorado. This most recent audit of the plan covered contract years 1988 through 1993. During 1993, BCBS of Colorado administered benefits for about 23,000 FEHBP subscribers in that state, representing about 1.3 percent of the total enrollees in the Government-wide Service Benefit Plan. FEHBP claims paid by the plan in 1993 totaled approximately $58 million.

We examined health benefits payments from January 1, 1991 through October 31, 1993, and administrative expenses from 1988 through 1993. Health claims benefits were not audited for contract years 1988 and 1989 due to expiration of the three-year record retention period for claims data. The total questioned costs for inappropriate charges to the FEHBP resulting from this audit amounted to $3,557,213, including $608,676 for lost investment income that would have otherwise accrued to the FEHBP trust fund. Listed below by audit category are

examples of some of the major findings resulting from our review of this plan.

Questioned Costs to FEHBP Total $3,557,213

Health Benefits

For contract year 1990 through October 31 of contract year 1991, our auditors questioned $376,281 in claim payments and $1,085,876 in supplementary and miscellaneous benefit amounts that did not comply with requirements under the plan's FEHBP contract. Questioned costs relating to claim payments included coordination of benefits with Medicare ($216,450), duplicate payments ($77,853), untimely filing ($21,950), and improper charges for private room accommodations ($60,028). Other health benefits areas we examined were hospital discounts the plan had not taken full advantage of with respect to FEHBP claims, as well as delays in returning refunds and crediting uncashed checks to the FEHBP. It should be pointed out that contract noncompliance regarding duplicate payments and uncashed checks was also an issue in a previous audit of this plan (Report No. 10-30-87-04). The following is a summary of one of the major findings of our current audit resulting in inappropriate health benefits charges to the FEHBP.

Hospital discounts. In examining benefit charges, we noted that the plan had not taken all available hospital discounts on FEHBP claims processed directly through the FEP central claims processing system. These claims, distinguished from those the plan processes locally, are known as direct data entry (DDE) claims. These discounts on DDE claims were not taken because the FEP system does not allow multiple discounts to be applied. While BCBS of Colorado manually calculates hospital discounts it negotiates with its network facilities and other discount-participating hospitals when using its local claims processing system, it did not make a similar effort to calculate manually hospital discounts on DDE claims going through the FEP central claims processing system. As a result, the FEHBP was overcharged $1,085,876 for undiscounted claims during the period of this audit.

Consequently, in addition to recommending the return to the FEHBP of $1,085,876 for claim payments not properly discounted, we also recommended that the OPM contracting officer direct BCBS of Colorado to work with the BCBS Association to develop procedures to recover discounts from hospitals on DDE claims and credit those resulting discounts to the FEHBP. In addition, we recommended that the plan calculate and credit lost discounts from the end of the period we audited (October 31, 1993) until the time the plan develops appropriate procedures to safeguard against such discount losses.

Administrative Expenses

Our auditors also examined administrative expenses charged to the FEHBP by BCBS of Colorado to determine whether they were actual, necessary and reasonable expenses incurred in accordance with the contract and applicable federal regulations. As a result, we made a determination that $353,155, including an amount for lost investment income, was owed to the FEHBP for overcharges. This review disclosed

FEHBP unallowable charges covering charitable contributions; entertainment costs; advertising expenses; health promotion activities, particularly the "Your Healthy Best" program; and various cost center allocations improperly charged to the FEHBP.

Internal control system deficiencies. We determined that the bulk of unallowable and/or unallocable costs charges to the FEHBP can be attributed to the plan's internal control system problems. For instance, we learned that the plan did not have system edits to identify unallowable costs. Instead, they relied primarily on manual adjustments. This method did not prove effective in removing all nonchargeable costs.

In response to our audit, the plan has stated its intention to expand management review and approval procedures to ensure that the formal cost allocation review process and the final cost submission adjustment workpapers properly identify and exclude nonchargeable expenses. While we have commended the plan for its efforts to correct these problems, we still felt it necessary to recommend that OPM's contracting officer direct the plan to implement system controls to ensure that future nonchargeable costs, including those dealing with cost centers, will be excluded from its cost submissions to the FEHBP.

$353,155 Cited for Unallowable Administrative Expenses and Lost Investment Income

Cash Management

The last major finding addressed in this audit concerns the plan's management of FEHBP funds from its letter of credit (LOC) account. The federal government pays its premiums to the plan through an LOC account, which is actually managed by the Blue Cross and Blue Shield Association. Through its management of the LOC, the BCBS Association also has a responsibility in this matter. Plans should not be receiving funds from the LOC until their payments to health providers and/or subscribers have cleared their respective banks. With regard to this plan, we discovered that it was receiving FEHBP funds an average of 9.5 days before such payments had cleared.

As a result of the BCBS Association's current reimbursement procedure, BCBS of Colorado has maintained excess FEHBP funds on hand. Furthermore, we determined that the plan had commingled FEHBP funds with other income-producing accounts and had not credited to the FEHBP interest earned on those excess funds as required by its FEHBP contract.

Based on our review of this plan's cash management practices, we calculated that the federal government lost $607,245 in investment income for contract years 1988 through 1993. We have recommended not only that the plan credit that amount to

the FEHBP but that the contracting officer direct the BCBS Association to adopt immediately the "checks-presented" method of executing drawdowns under the LOC program.

Cash Management Practices Result in $607,245 Loss to FEHBP

Blue Cross and Blue Shield of Maryland in Owings Mills, Maryland

Report No. 10-06-93-009

September 24, 1996

Blue Cross and Blue Shield of Maryland (BCBS of Maryland) has its headquarters in Owings Mills, Maryland. This audit covered contract years 1988 through 1992. For the last contract year we audited (1992), the plan administered benefits for about 76,000 FEHBP subscribers in the state, which constituted four percent of the plan's total enrollees for that year.

We examined health benefits payments from January 1, 1991 through December 31, 1992, and administrative expenses from 1988 through 1992. For the two years we audited health benefit payments, BCBS of Maryland paid over 2.5 million claims, amounting to $308.3 million in benefit payments. Health claims benefits were not audited for contract years 1988 and 1989 nor administrative expenses for 1987 due to expiration of the records retention period in each instance.

Our audit resulted in questioned costs for inappropriate charges to the FEHBP totaling $6,004,195, including $1,359,601 for lost investment income to the FEHBP trust fund. After reviewing the audit of BCBS of Maryland that preceded this one, we noted that the plan had continued its FEHBP contract noncompliance in several areas, including duplicate payments, refunds, coordination of benefits, and records retention. Listed below by audit category are several of the major findings resulting from our current audit.

Questioned Costs to FEHBP Total $6,004,195

Health Benefits

To test BCBS of Maryland's compliance with FEHBP health benefit provisions, we examined 26 claim samples, consisting of 2,264 claim lines, representing $4,222,697 in health benefits payments made from January 1, 1991 through December 31, 1992. Among the costs we questioned were health benefits charges relating to improper coordination of benefits with Medicare ($960,608), duplicate payments ($139,682),

certain noncovered medical procedures ($17,023), and specific claims with inadequate supporting documentation ($12,351). In addition, we noted problems with the timely crediting of health benefits payment refunds to the FEHBP as prescribed in its FEHBP contract, resulting in a loss of interest income amounting to $290,849. We also found after reviewing the FEP claims system that significant problems with the FEP claims system existed and that the plan had not established procedures to readily identify, control and reconcile FEP accounts.

In all, inappropriate health benefits charges to the FEHBP totaled $1,423,293. We have recommended that OPM's contracting officer direct the plan to return this amount to the FEHBP trust fund along with establishing or strengthening controls to avoid these and other problems described in our audit report.

Administrative Expenses

Our auditors also examined administrative expenses charged to the FEHBP by BCBS of Maryland and determined that in many instances they were not reasonable or proper expenses under the FEHBP contract. The following illustrate some of our findings in this area.

Occupancy costs: In contract years 1991-1992, the plan made incorrect occupancy (rent) charges to the FEHBP by reallocating costs through out-of-system adjustments to cost centers at the end of the year for which proper justification and accounting support could not be substantiated. The amount in question was $318,155. The BCBS Association has concurred with this finding.

Nonchargeable cost centers: BCBS of Maryland allocated and charged the FEHBP costs centers that did not benefit the FEHBP. As a result, in 1991 and 1992 contract years, the plan overcharged the FEHBP $470,875. The BCBS Association also agreed with this finding and has assured us that the plan has strengthened its procedures to ensure that the FEP is allocated only costs from costs centers that actually benefit the FEHBP.

Executive Compensation

The salary increases for executives at BCBS of Maryland during the period 1989 through 1992 were excessive. During a review of executive compensation, we observed a trend of significant increases in the total compensation paid to the top executives of the plan. This trend was not consistent with national statistics for executive salaries. In our audit report, we stated that it was unreasonable for plan executives to be enjoying pay raises of 7.8 percent to 44.8 percent while the economy and the plan's performance during the time frame in question suggested minimal or no increase in salary to have been more appropriate. As a consequence, we recommended that the contracting officer require the BCBS Association to monitor the plan's compensation policies to ensure that unreasonable salaries are not allocated and charged to the FEHBP in the future.

Auditors Determine Executive Compensation Excessive

Employee Organization Plans

These plans also fall in the category of experience-rated and may operate or sponsor participating health benefits programs. Employee organization plans operate on an indemnity and fee-for-service basis. Members are free to obtain treatment through facilities or providers of their choice for which claims are submitted to the carrier for adjudication and payment. During the reporting period, we did not issue any employee organization plan audit reports.

OTHER EXTERNAL AUDITS

As requested by Office of Personnel Management procurement officials, our OIG conducts pre- and post-award contract audits relating to the acquisition of goods and services by agency program offices. Our office also conducts audits of the local organizations of the Combined Federal Campaign (CFC), the solely authorized fund-raising drive conducted in federal installations throughout the world.

Pre-Award and Post-Award Contracts

These contract audits are performed to ensure that costs anticipated to be, or claimed to have been, incurred under the terms of these contracts are accurate and in accordance with provisions of the Federal Acquisition Regulation. The results of these audits provide OPM procurement officials with the best information available for use in contract negotiations and oversight. In the case of post-award contracts, for instance, the verification of actual costs and performance charges may be useful in negotiating contract modifications as these relate to cost-savings and efficiency.

We did not conduct any external contract audits in this area during the period.

Combined Federal Campaign

On March 18, 1961, Executive Order 10927 transferred to the chairman of the U.S. Civil Service Commission (the precursor of OPM), the responsibility to arrange for national voluntary health and welfare agencies to solicit funds from federal employees and members of the armed services at their place of employment. Since then, there have been two more executive orders, one public law (P.L. 100-202), and the issuance of federal regulations (5 CFR Part 950) detailing the eligibility of national and local organizations and charities as participants, the role of local combined federal campaigns, and the oversight responsibilities of the Office of Personnel Management with respect to the Combined Federal Campaign.

One of our agency's oversight responsibilities is auditing the local CFCs, a role our OIG has been performing since 1991. These audits focus on the eligibility of local charities to participate in the campaigns, local campaign compliance with CFC regulations, and the testing of the various local campaigns' financial records. CFC audits will not ordinarily identify savings to the government, because the funds involved are charitable donations made by federal employees.

Since 1961, the CFC has netted over $3.2 billion in charitable contributions. Our most recent statistical data available comes from the 1995 CFC. Approximately 415 local campaigns participated in the 1995 CFC, with federal employee contributions reaching $189 million. Expenses associated with conducting the 1995 CFC totaled $15.6 million. During this reporting period, we issued three CFC reports, a listing of which can be found in Appendix IV on page 40 of this report.

OPM INTERNAL ACTIVITIES AUDITS

Our office also has responsibility for conducting a wide range of audit activity covering OPM programs and administrative operations. This activity includes such diverse areas as financial statement audits required by the Chief Financial Officers Act; President's Council on Integrity and Efficiency government-wide audits; audits of agency compliance with laws and regulations, such as the Prompt Payment Act and the Federal Managers' Financial Integrity Act; and performance audits of OPM programs that involve the range of the agency's responsibilities for retirement, employee development, and personnel management activities.

We have established a one-to-five year optimum audit cycle for each of these audit areas, depending upon the existence of legal requirements to conduct audits and the materiality and other risk factors associated with each activity. However, due to resource limitations, we have eliminated all internal audits from our agenda so that the staff who work on OPM internal audits can dedicate their time to auditing the fiscal year 1996 financial statements.

Fiscal Year 1996 Financial Statements Audits

To meet the requirement to audit all FY 1996 OPM financial statements, we have elected to have benefits programs financial statements audited by an independent public accountant (IPA). OIG will devote available internal audit staff to audits of the salaries and expenses accounts and revolving fund financial statements.

The decision to have an IPA audit the benefits programs financial statements was made early in FY 96 when program management agreed to provide funding for the contract. Our office developed a Request for Proposals (RFP); and, after lengthy discussions with program management over contract requirements, the RFP was issued in late July 1996. A contract is expected to be awarded in late October. Our role in the benefits programs financial statement audits will be to ensure that the IPA performs in accordance with the contract and complies with government auditing standards and other authoritative references pertaining to OPM's financial statements.

During the current reporting period, our office issued opinions on several of the benefits programs FY 1995 financial statements. These are described in the audit narrative below. Our office did not issue any reports on audits of OPM programs and administrative activities.

Report on Office of Personnel Management's Fiscal Year 1995 and 1994 Benefits Programs Financial Statements

Report No. 2F-00-95-101

As referenced in the OPM internal activities audit preface, under the provisions of the Chief Financial Officers Act of 1990, our office is required to audit and report on the financial statements of OPM's reporting entities. The most significant results of our audits of OPM's fiscal year 1995 and 1994 benefits programs statements are reported below.

Our office did not have sufficient resources to audit the fiscal year 1995 and 1994 revolving fund and salaries and expenses accounts financial statements; therefore, we could not opine on them. We have, however, performed compilations and limited audit procedures in these areas and have discussed this work in our recently issued draft report on OPM's internal controls and related management.

Benefits Programs Financial Statements

Retirement Program. Based on our audits of the retirement program's financial statements, we offered an unqualified opinion on the Statement of Net Assets Available for Benefits as of September 30, 1995 and 1994, and the Statement of Actuarial Present Value of Accumulated Plan Benefits as of September 30, 1995 and 1994.

The scope of our audit did not include the Statement of Changes in Net Assets Available for Benefits for the fiscal year ended September 30, 1995, and we expressed no opinion on this financial statement. We disclaimed an opinion on the Statement of Changes in Net Assets Available for Benefits for the fiscal year ended September 30, 1994. Our disclaimer was based on the aggregate effect of material internal control weaknesses in critical components of the electronic data processing (EDP) general controls and application programs security, inadequate controls over premium reconciliations with employer agencies, and material weaknesses in other controls over annuity payments.

As an alternative to attempting to audit and report, or disclaim, on a statement produced from a control environment known to be materially weak in critical areas, OIG teamed with Office of the Chief Financial Officer (OCFO) and the Retirement and Insurance Service to identify corrective actions and compensating controls that would improve the internal control structure and increase the reliance users could put on data produced within that control structure. This alternative proved to be an efficient and effective use of available resources. The most significant results of the teaming effort include:

- Correction of material weaknesses in the area of EDP security and general controls to a sufficient extent to reduce this weakness to a reportable condition.

- Identification and implementation of compensating internal controls in the area of agency reports of enrollment and collections to a sufficient extent,

when combined with extended audit procedures, to reduce this weakness to a reportable condition.

- Design and testing of a methodology that, when fully implemented, should provide OPM with the ability to confirm that revenues reported by OPM are in
agreement with amounts recorded in the financial records of the agencies submitting those revenues.

- Recommendations for improved coordination of internal control and audit requirements between OPM's OCFO and OIG and the OCFOs and OIGs of other agencies participating in the benefits programs.

The retirement program has made, or is in the process of making, significant improvements in internal control. Nevertheless, we continued to find material weaknesses in the following areas:

- Operating policies and procedures were either not current or not documented.

- Major systems were not documented by current, complete manuals and were not integrated with other systems.

- Debt collection and management policies and procedures were not adequate.

- Transactions and balances with the health benefits program, life insurance program, Internal Revenue Service, and other third parties were not reconciled. Based on analytical procedures, we estimated that accounts recording amounts withheld from annuitants were misstated by approximately $30 million. In addition, as noted below, amounts due to the health benefits and life insurance programs were not reconciled with the receivables recorded on those programs' books.

Teaming Effort to Improve Internal Control Produces Significant Results

Health Benefits Program. Our opinion on the health benefits program fiscal year 1995 and 1994 statements was qualified, as it was in previous years, for the effects of any adjustment or disclosure that may have been necessary had management installed an adequate control system over amounts and balances reported by the experience-rated health benefits insurance carriers and had we been able to examine sufficient evidence regarding the program's equity in these carriers.

Our office and RIS are working together as a team to bring better financial accountability and increased oversight to the health benefits program and to ensure that the insurance carriers meet federal government financial reporting and audit

requirements. As part of this effort, the team has requested comments and suggestions from a representative group of the carriers in an effort to develop and implement cost-effective reporting and audit requirements.

The health benefits program has made significant improvement in its EDP control environment and other areas of material weakness. However, we continued to find material internal control weaknesses in the following areas:

- Operating policies and procedures were either not current or not documented.
- Major systems were not documented by current, complete manuals and were not integrated with other systems.
- An adequate control system over experience-rated carrier reported activity and balances used for financial statement reporting did not exist (see discussion above).
- Transactions and balances with the retirement program were not reconciled. There is a $29.1 million difference between the liability to the health benefits program recorded in the retirement program's records and the receivable recorded in the health benefits program's records.

OIG and RIS Work Together to Improve Financial Accountability of Health Insurance Carriers

Life Insurance Program. Our opinion on the life insurance program's fiscal year 1995 and certain of the fiscal year 1994 financial statements was unqualified.

The life insurance program has also made significant improvement in its EDP control environment and other areas of material weakness. However, we continued to find material internal control weaknesses in the following areas:

- Operating policies and procedures were either not current or not documented.
- Major systems were not documented by current, complete manuals and were not integrated with other systems.
- Transactions and balances with the retirement program were not reconciled. There is a $9.3 million difference between the liability to the life insurance program recorded in the retirement program's records and the receivable recorded in the life insurance program's records.

In addition, we reported that the life insurance program has not required the program administrator, MetLife, to maintain a contingency reserve as required by the Federal

Employees' Group Life Insurance Act of 1954. For this reason, it was not possible to fund the $11 million of fiscal year 1995 payments and accruals for living benefits expenses by reducing the program's contingency reserve as required by the Living Benefits Act enacted in October 1994.

Investigative Activities

The Office of Personnel Management administers benefits from its trust funds for all federal civilian employees and annuitants participating in the federal government's retirement, health and life insurance programs. These trust fund programs cover approximately 5 million current and retired federal civilian employees and disburse over $56 billion annually. The investigation of fraud involving OPM's trust funds occupies the majority of our OIG investigative efforts.

During this reporting period, we have continued to aggressively pursue criminal and civil sanctions against both individuals and corporate entities. These efforts have produced ten arrests and ten convictions. More importantly, however, they have resulted in judicial and administrative monetary recoveries totaling $1,180,628. Other investigative efforts resulted in the detection of 11 ongoing frauds in the Civil Service Retirement System (CSRS), with a projected savings of $424,064 to the Civil Service Retirement and Disability trust fund over the next five years. Overall, we opened 44 investigations and closed 28 during this reporting period, with 125 still in progress at the end of the period. (See Table 1 for investigative activity highlights on page 24 of this section.)

Calls received on our retirement and special investigations hotline and our health care fraud hotline, along with complaints mailed in, totaled 1,119. As we typically experience during the second half of the fiscal year, our complaint activity has decreased from the previous reporting period. Complaint activity is usually more active in the fall of each year when the FEHBP open season brochures, which contain information on how to report fraud to the OIG, are distributed. Additional information, including specific activity breakdowns for each hotline, can be found on pages 25-26 in this section.

In the retirement area, we have continued our proactive efforts to identify fraud by routinely reviewing CSRS annuity records for indications of unusual circumstances, as well as maintaining contact with the federal annuitant population. While our recoveries in this area are, for the most part, smaller than in the health care fraud area, criminal prosecutions and sentences tend to be more significant. In addition to the typical fraud scenarios involving individuals who continue to take the annuity payments issued to deceased beneficiaries, cases involving more unique methods of retirement fraud were investigated and closed during this period. Two of these cases are highlighted on pages 23-24.

On the following pages, we have provided narratives relating to health care and retirement fund fraud and abuse cases we worked and closed during the reporting period.

Retirement Fund Fraud and Abuse

In accordance with its mission to prevent and detect fraud, OIG special agents routinely review CSRS annuity records for indications of unusual circumstances. Using excessive annuitant age as an indication of potential fraud, our investigators attempt to contact the annuitants and determine if they are alive and still receiving their benefits. In addition, we receive inquiries from OPM program offices, other federal agencies, and private citizens that prompt us to investigate cases of potential fraud.

Cited below are narratives related to three of the cases in the area of retirement fraud and abuse we completed during this reporting period.

Family Member Identified in Annuity Fraud

An OIG special agent was responsible for discovering an ongoing annuity fraud after he noticed some irregularities in an annuitant's records maintained by OPM. Following up on a suspicion that there was something wrong with the annuity file, the agent contacted the Social Security Administration (SSA) and determined that the federal annuitant died in May 1989. Because the death had never been reported to OPM, our agency issued annuity payments totaling $154,491 after the annuitant's death. Additional payments were made by OPM for the deceased annuitant's health insurance coverage totaling $7,061.

After obtaining a copy of the annuitant's death certificate and reviewing copies of the negotiated U.S. Treasury checks that were issued after the annuitant's death, the OIG special agent identified the annuitant's daughter as the suspect in this case. Unaware of the extent of the agent's knowledge, the annuitant's daughter maintained in several telephone contacts by the agent that her father was alive and she was caring for him. In fact, even after OIG special agents confronted the daughter in person and showed her the death certificate naming her as the informant, she continued to maintain that her father was alive at the time she forged and negotiated the annuity payments.

Unfortunately, the daughter had substance abuse problems and did not have any assets. The U.S. Attorney's office deferred criminal prosecution of the daughter due to her personal and medical problems in exchange for her voluntary agreement to receive counseling and perform community service. OPM administratively recovered $7,061 from the health insurance company for the erroneous health benefits coverage. Although the fraudulent annuity payments will never be restored to the Civil Service Retirement System fund, the proactive effort on this case will result in a savings to the fund of over $31,000 a year.

OIG Proactive Inquiry Detects $161,552 Fraud

National Guard Soldier Fakes Brain Tumor

This case was brought to the attention of the OIG by the Social Security Administration, which discovered that a National Guard soldier had fraudulently attempted to receive social security disability benefits for a brain tumor that did not exist. The SSA became suspicious of the soldier's claim when they asked her to sign a medical release form so it could review her medical records and the soldier initially refused to do so. Inquiry into the matter by the SSA determined that the soldier falsified medical documents from two different physicians indicating that they had treated her for a brain tumor when, in fact, they had not.

Our investigation determined that the soldier had submitted the identical false documentation to OPM in an effort to obtain disability benefits under the Federal Employees Retirement System. OPM approved the soldier's application to retire on a medical disability and began issuing monthly benefit payments to her. Once we brought this matter to the attention of the agency, OPM immediately suspended benefit payments to the soldier. However, payments totaling $13,522 had been issued up until that point. An OIG special agent confirmed through interviews with the physicians that the soldier had falsified the medical documentation. The agent further determined that the soldier lied to her coworkers about her illness and had received and used over $3,800 in donated sick leave.

In March 1996, the former soldier pled guilty to one count of violating 18 U.S.C. § 1001, relating to false statements. In May 1996, she was sentenced to six months home confinement and ordered to pay restitution totaling $2,500.

Former Soldier Sentenced to Home Confinement and Restitution

Disability Retiree Falsifies Earnings Statement

Each year, OPM surveys disability annuitants to determine if the annuitant earned wages and/or self-employment income in excess of the amount allowable by law. Under 5 U.S.C. § 8337(d), a recipient of a disability retirement annuity becomes ineligible for the annuity if that individual earns income from wages or self-employment equal to at least 80 percent of the current rate of pay of the position occupied immediately before retirement. In two consecutive years, one of OPM's disability annuitants certified to OPM that his income during those years was substantially less than he actually earned. The disabled annuitant, who retired from his position as a mechanical engineer due to a coronary deficiency, actually earned income during those years in amounts that exceeded the amounts allowable by law.

As a result of his two false statements to OPM, the disability annuitant continued to receive annuity payments he was not entitled to receive in the amount of $40,544.

Despite the fact that the disabled annuitant had already initiated repayment to OPM of the fraudulent funds he received, the U.S. Attorney's office indicated an interest in prosecuting him. OIG special agents interviewed the annuitant, and he admitted providing false information to OPM due to financial difficulties. In October 1995, the annuitant pled guilty to one count of violating 18 U.S.C. § 641, relating to theft of government funds. In addition to making full restitution, the annuitant was sentenced to one year probation and ordered to pay a fine of $1,000.

Disabled Annuitant Sentenced to One Year Probation for Theft of Government Funds

Health Care-Related Fraud and Abuse

Our OIG special agents are in regular contact with the numerous insurance carriers participating in the FEHBP to provide an effective means for reporting instances of possible fraud by health care providers and FEHBP subscribers. Additionally, our office maintains liaison with federal law enforcement agencies involved in health care fraud investigations and participates in several health care fraud working groups on both national and local levels.

The following narratives describe two of the cases we concluded in the area of health care fraud during this reporting period.

Insurance Carrier Employee Submits False Claims

Our office initiated an investigation in this case upon receipt of information from the National Association of Letter Carriers Health Plan (NALC health plan) regarding one of its employees suspected of submitting fraudulent health insurance claims. The employee, a supervisory claims examiner, was interviewed and admitted fabricating insurance claims between 1992 and 1996 for which he received $82,791 in FEHBP payments. The employee submitted claims using the names of legitimate subscribers of the NALC health plan with the same last name as his own. On September 13, 1996, in U.S. District Court in Alexandria, Virginia, the employee plead guilty to theft of government funds and is scheduled to be sentenced on December 6, 1996.

FEHBP Carrier Employee Admits Insurance Fraud

FEHBP Provider Fraud

In 1994, at the request of the U.S. Attorney's office, an investigation was initiated of The Kids of North Jersey, a clinic which was suspected of billing the FEHBP for counseling services that were not attended by a physician, psychiatrist or social worker. As a result of the OIG investigation, The Kids of North Jersey agreed to a civil settlement in this matter in which they will reimburse the FEHBP $45,500. In addition, the clinic has voluntarily agreed to refrain from participation in the FEHBP for a period of three years.

Provider Agrees to Restitution and Voluntary Debarment

TABLE 1: Investigative Highlights

Judicial Actions:	
Arrests	10
Indictments	9
Convictions	10
Administrative Actions:[1]	2
Judicial Recoveries:	
Fines, Penalties, Restitutions and Settlements	$1,169,366
Administrative Recoveries:	
Settlements and Restitutions	$11,262
Total Funds Recovered	$1,180,628

[1]*Includes suspensions, reprimands, demotions, resignations, removals, and reassignments.*

OIG Hotlines

The OIG maintains two hotlines, the Retirement and Special Investigations hotline and the Health Care Fraud hotline.

Retirement and Special Investigations Hotline

The Retirement and Special Investigations hotline provides the same assistance as traditional OIG hotlines. For example, we receive inquiries from OPM employees, contractors, and others interested in reporting waste, fraud and abuse within the agency. Callers, or those who choose to write letters, can report information openly, anonymously or confidentially without fear of reprisal.

The Retirement and Special Investigations hotline and complaint activity for this reporting period included 88 telephone calls, 56 letters, 27 agency referrals, 1 walk-in and 259 complaints initiated by the OIG, for a total of 431. Our administrative monetary recoveries resulting from retirement and special investigation complaints totaled $1,021. The administrative monetary recovery amount is lower than reported in previous semiannual reports due to a change in how investigations are tracked in the OIG. Some recoveries that previously had been recorded as administrative recoveries are now included in Table 1.

OIG-initiated complaints: Complaints initiated by our office can be one of two types. The first occurs when the agency has already received information indicating an overpayment to an annuitant has been made, and our review leads us to determine there are sufficient grounds to justify our involvement due to the potential for fraud. There were 12 such complaints associated with agency inquiries during this reporting period.

The second type of OIG-initiated complaint occurs when we view the agency's automated annuity records system for certain items that may indicate a potential for fraud. At that point, we initiate personal contact with the annuitant to determine if further investigation is warranted. This proactive activity resulted in 247 instances where our office initiated personal contacts to verify the status of the annuitant.

Health Care Fraud Hotline

The Health Care Fraud hotline was established to handle complaints from subscribers in the Federal Employees Health Benefits Program administered by OPM. The hotline number is listed in the brochures for all the plans associated with the FEHBP.

While the hotline is designed to provide an avenue to report fraud by subscribers, health care providers or FEHBP carriers, frequently callers have requested assistance with disputed claims and services disallowed by the carriers. Each caller receives a

follow-up call or letter from either the OIG hotline coordinator, the insurance carrier or another OPM office as appropriate.

The Health Care Fraud hotline and complaint activity for the period involved 495 telephone calls and 193 letters, for a total of 688. During this period, the administrative monetary recoveries pertaining to health care fraud complaints totaled $10,241.

TABLE 2: Hotline Calls and Complaint Activity

Retirement and Special Investigations Hotline and Complaint Activity:	
Retained for Investigation	333
Referred to:	
OIG Office of Audits	0
OPM Groups and Offices	42
Other Federal Agencies	56
Total	431
Health Care Fraud Hotline and Complaint Activity:	
Retained for Investigation	169
Referred to:	
OPM Groups and Offices	190
Other Federal/State Agencies	64
Health Insurance Carriers or Providers	265
Total	**688**
Total Contacts	**1119**

Evaluation and Inspections Activities

Through our evaluation and inspections function, we are providing assistance to agency program managers in their efforts to determine the feasibility of new initiatives and the effectiveness and efficiency of existing operational strategies. Our staff conducts independent analytical reviews that often serve as the cornerstone for strategies to improve the delivery of services throughout the agency.

This office provides the agency with a unique tool to address some of the pressing problems associated with today's government reorganizing. The evaluative process used by this office, whether requested or mandated, focuses on current issues, such as reduced funding, increased workloads, decreasing staffing levels, inefficient or ineffective services, customer or public questions concerning delivery of services, and the lack of objective evaluative data to use in determining the impact of programs.

OPM has been on the forefront of the Administration's efforts to improve the quality of services and reduce the size of government. The agency's program offices have experienced reorganizations, staff reductions, and new program mandates during the last few years with the intended objective of becoming a "model agency" for the twenty-first century. Questions have been raised both within the agency and from other interested parties concerning how OPM will be able to meet these challenges. We are now working with agency offices to conduct evaluations of existing services that will formulate strategies that can result in improved services, more accountability, and fewer resource demands.

As previewed in our last semiannual report, our staff has commenced reviews of two common service administrative offices in OPM. Of concern is whether reduced funding and the resulting reductions in staff within these offices have made a dramatic impact on their servicing abilities. These evaluations will determine if the administrative offices can provide a level of service necessary to support the redefined core functions of the agency. While the services provided by administrative functions do not have a high level of visibility outside the agency, nevertheless, the ability of program offices to achieve the agency's primary objectives are closely associated with these operations.

Part of the OPM strategy for reorganization was the privatization of background investigation services. There were many questions raised by Congress, the public, and federal agencies concerning this approach to downsizing and the agency's ability to ensure that the federal community will continue to have reliable and timely background investigations. Within this context, during this reporting period, we conducted an evaluation of OPM's ability to protect the federal government's interests while implementing the

privatization strategy. A summary of that evaluation can be found on the following page.

We also conducted an inspection during this reporting period that focused on questions raised by Congress concerning the employment of a political appointee to a career position. Many of the questions addressed in this report involved the methods used by the agency in processing high-level position appointments. A summary of that inspection also follows.

Evaluation of OPM Management of the Privatization of Background Investigations

In December 1994, OPM announced plans to privatize the training and background investigative functions of the agency. During the subsequent 18 months, the privatization of the background investigation (BI) program was debated at several levels of federal and state government, including the executive branch and Congress, as well as within the private sector. Many of the issues raised in these discussions involved OPM's ability to protect the federal government's interest when a private contractor was actually performing this work.

In May 1996, we initiated an evaluation of OPM's plans to oversee contractor performance. Several questions concerning contingency planning and privacy protection issues related to BIs were addressed in this analysis. The study team paid particular attention to management controls and OPM's ability to ensure the continuation of quality service to customer agencies.

Though our OIG study team did not find any major immediate impediments to privatization, there were findings that resulted in recommendations that OPM take specific actions to protect the long-range interests of the government. For example, we noted during our review that OPM management had not developed a contingency plan to ensure continuation of quality and timely BIs in the event of contractor default or other disruption of services. In response to this finding and the accompanying recommendation, various OPM program offices worked together, including the Investigations Service (IS), to develop contingency plans that they feel will provide for alternative ways to provide BIs if the contractor fails to deliver services for any reason.

Though IS over the years has developed strategies that it believes will ensure that only those individuals with a legitimate need have access to the appropriate data file, their overall system security plan had not been documented at the time of the study. In addition, many of the critics of the privatization plan had cited as their reasons for opposing the use of a full-time contractor the risk of unauthorized exposure and use of information for purposes other than for the clearance of federal employees. This underscored the need for IS to monitor the use of files closely to identify improper usage.

With these concerns in mind, our study team made the following recommendations:

- Develop a written security plan.
- Install on-screen warnings to system users of the restrictions on the allowed uses of information.
- Develop an automated report system that tracks trends in individual access of information.
- Apply limitations on the length of time a case file remains active on the system.

All four recommendations are now being implemented by IS management.

OIG Recommends Contingency Plan for Privatized Function

Review of Partnership Center Director Selection

Federal employment guidance concerning the selection of political appointees to career positions is issued to agencies by OPM every four years immediately proceeding the presidential elections. The purpose of this guidance is to prevent the practice of "burrowing in" of political appointees into career positions without the use of merit selection procedures in anticipation of a change in administrations. The selection made by OPM Director James B. King to the position of director of the newly created Partnership Center was a person who was serving as chief of staff to Director King--a noncareer Senior Executive Service (SES) position. For that reason, we conducted an inspection to ensure that the appropriate procedures were used by the agency during the position classification, recruiting and selection processes.

The new position, established appropriately as a career general position, had been evolving over a two-year period and, when finally announced in December 1995, was subjected to the same merit staffing requirements as any other SES posting in the government. Our review revealed that the merit selection process was followed throughout. While no impropriety was found, we did make recommendations to tighten administrative procedures used in all OPM SES appointments.

OIG Finds No Impropriety in Selection Process for Career SES Position

Index of Reporting Requirements (Inspector General Act of 1978, As Amended)

APPENDIX I
Final Reports Issued With Questioned Costs
April 1, 1996 to September 30, 1996

		Number of Reports	Questioned Costs	Unsupported Costs
A.	Reports for which no management decision had been made by the beginning of the reporting period	13	$ 30,351,518	$ 20,400
B.	Reports issued during the reporting period with findings	22	42,187,316	391,881
	Subtotals (A+B)	35	72,538,834	412,281
C.	Reports for which a management decision was made during the reporting period:	21	38,052,885	20,400
	1. Disallowed costs		32,645,550	20,400
	2. Costs not disallowed		5,407,335	0
D.	Reports for which no management decision has been made by the end of the reporting period	14	34,485,949	391,881
	Reports for which no management decision has been made within 6 months of issuance	0	0	0

APPENDIX II
Final Reports Issued With Recommendations for Better Use of Funds
April 1, 1996 to September 30, 1996

	Number of Reports	Dollar Value
No activity during this reporting period	0	$ 0

APPENDIX III - A
Insurance Audit Reports Issued
April 1, 1996 to September 30, 1996

Subject *(Standard Audits)*	Report Number	Issue Date	Questioned Costs	Unsupported Costs
Community Health Care Plan in New Haven, Connecticut	71-00-94-004	April 23, 1996	$ 474,206	$
PacifiCare of California, Inc., in Cypress, California	CQ-00-93-36	April 23, 1996	1,941,463	
Aetna Health Plan of Georgia in Atlanta, Georgia	F3-00-93-32	April 30, 1996	1,216,140	
Kaiser FHP of the Mid-Atlantic States, Inc., in Rockville, Maryland	E3-00-95-012	May 8, 1996	391,881	391,881
Health Insurance Plan of Greater New York in New York, New York	51-00-96-004	May 22, 1996	0	
Greater Atlantic Health Service in Philadelphia, Pennsylvania	27-00-93-27	May 29, 1996	387,675	
Columbia Medical Plan in Columbia, Maryland	67-00-92-079	June 28, 1996	11,992,149	
Blue Cross and Blue Shield of Colorado in Denver, Colorado	10-30-94-042	July 11, 1996	3,557,213	
Constitution HealthCare, Inc., in North Haven, Connecticut	BN-00-93-43	August 15, 1996	468,820	
Blue Cross Blue Shield Association's Federal Employee Program Director's Office Procurement Process in Washington, DC	99-PP-96-101	August 22, 1996	n/a	

Group Health, Inc., in Minneapolis, Minnesota	53-00-95-013	August 28, 1996	$	(514,080)	$	
Qual-Med Health Plan - New Mexico in Albuquerque, New Mexico	PX-00-93-26	August 28, 1996		2,646,668		
CIGNA HealthPlan of Texas, Inc. - Houston and EQUICOR Health Plan, Inc. - Houston in Houston, Texas	UH-00-93-051	August 30, 1996		1,984,029		
Key Health Plan in Indianapolis, Indiana	GH-00-95-004	September 6, 1996		2,118,443		
Lovelace Health Plan in Albuquerque, New Mexico	Q1-00-95-011	September 18, 1996		499,352		
Health Plan of America in Cypress, California	AX-00-93-58	September 18, 1996		2,540,576		
Blue Cross and Blue Shield of Maryland in Owings Mills, Maryland	10-06-93-009	September 24, 1996		6,004,195		
HMO Kentucky Experience-Rated Review	FG-00-96-14	September 26, 1996		n/a		
TOTALS			**$**	**35,708,730**	**$**	**391,881**

APPENDIX III - B
Insurance Audit Reports Issued With Recommendations for Better Use of Funds
April 1, 1996 to September 30, 1996

Subject (Rate Reconciliation Audits)	Report Number	Issue Date	Dollar Value
PruCare of Atlanta in Atlanta, Georgia	EZ-00-96-017	June 3, 1996	$ 105,912
PruCare of Memphis in Memphis, Tennessee	UB-00-96-018	June 3, 1996	0
CIGNA HealthCare of Arizona - Phoenix in Phoenix, Arizona	16-00-96-016	June 4, 1996	409,703
NYLCare Health Plans, Inc. - New Jersey Region in New York, New York	HK-00-96-021	July 10, 1996	613,663
Intergroup of Arizona in Tucson, Arizona	A7-00-96-019	July 30, 1996	1,148,042
Matthew Thornton Health Plan in Bedford, New Hampshire	NX-00-96-022	August 6, 1996	0
Complete Health of Arkansas in Little Rock, Arkansas	QC-00-96-026	August 8, 1996	(55,431)
Group Health Plan, Inc., in St. Louis, Missouri	MM-00-96-023	August 14, 1996	1,438,335
Group Health Cooperative of Puget Sound in Seattle, Washington	54-00-96-020	August 15, 1996	2,818,362
Pacificare of California in Cypress, California	CQ-00-96-025	August 29, 1996	0
TOTALS			**$ 6,478,586**

Appendix IV
Combined Federal Campaign Audit Reports Issued
April 1, 1996 to September 30, 1996

Subject	Report Number	Issue Date	Funds Put to Better Use	Questioned Costs
The 1993 and 1994 Combined Federal Campaigns of Central Maryland	2A-CF-95-204	April 2, 1996	$	$
The 1993 and 1994 Combined Federal Campaigns of Maricopa County - Phoenix, Arizona	2A-CF-95-200	May 8, 1996		
The 1993 and 1994 Combined Federal Campaigns of Lake County, Illinois	2A-CF-95-203	July 26, 1996		

Appendix V
Internal Audit Reports Issued
April 1, 1996 to September 30, 1996

Subject	Report Number	Issue Date	Funds Put to Better Use	Questioned Costs
Office of Personnel Management's Fiscal Year 1995 and 1994 Benefits Programs Financial Statements	2F-00-95-101	May 29, 1996	$ 0	$ 0
TOTALS			**$ 0**	**$ 0**